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ABSTRACT

Although the terms autonomy and advocacy have proliferated in nursing literature and in nursing curricula over the past decade, the degree to which registered nurses claim these dimensions in their practices and in their thinking has remained unknown. A study was conducted to determine the relationship between nurses' self-concepts and their attitudes toward autonomy and client advocacy, and rejection of traditional role limitations associated with nursing. A random sample of 106 female registered nurses (RNs) completed the "Tennessee Self Concept Scale" (TSCS) and "Pankratz Nursing Questionnaire" (PNQ) and provided demographic data on basic nursing education, highest degree held, year RN received, years active in nursing, current employment status, position, and field or practice area in nursing. The results revealed that the nurse respondents scored high on all selected dimensions of the TSCS. There was a significant relationship revealed between self-concept and advocacy, and between self-concept and rejection of traditional role limitations. In addition, a significant positive correlation was found between autonomy and highest degree held, and other serendipitous findings were revealed between demographic data and the variables under investigation. (Author/NRB)

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The Self Concept of Nurses in Relation to Autonomy, Advocacy, and Traditional Role Rejection

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ABSTRACT

The terms autonomy and advocacy have proliferated in nursing literature and in nursing curricula over the past decade. To what degree the rank and file registered nurse claims these dimensions in her practice and in her thinking has remained unknown. Accordingly, this study examined a random sample of female registered nurses (N=106) from a midwestern state utilizing the Tennessee Self Concept Scale (TSCS) and the Pankratz Nursing Questionnaire (PNQ) together with demographic data to determine the relationship between the nurses' self concepts and their attitudes toward autonomy and client advocacy, and rejection of traditional role limitations associated with nursing. The registered nurse respondents scored high on all selected dimensions of the Tennessee Self Concept Scale. There was a significant relationship revealed between self concept and advocacy, and between self concept and rejection of traditional role limitations. In addition, a significant positive correlation was found between autonomy and highest degree held, and other serendipitous findings were revealed between demographic data and the variables under investigation.

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AUTONOMY, ADVOCACY AND TRADITIONAL ROLE REJECTION

RELATED TO SELF CONCEPT IN REGISTERED NURSES

Characteristics of nursing students have been changing over the past decade as observed by nurse educators, but not extenively researched. Dunkelberger (1984) observed in his study that recruits to nursing are evidencing less altruistic attitudes and more interest in monetary rewards. To what extent these characteristics are beginning to impact nursing practice is not yet known. Historically, nurses have not been staunce advocates for themselves, nor others. This, too, is changing. In the last decade much has been written about client advocacy as well as nursing autonomy. If one defines advocacy simply "to speak for" or "in favor of" nurses can be categorized as being patient advocates since the inception of nursing. However, in its current context advocacy has become more than simply "speaking for", but rather giving information, once regarded as sacred, to patients so that they may make informed choices regarding their own health care. This is more than a giant leap for nurses.

However, to what extent physicians permit or allow once compliant, passive patients to participate in joint decision making regarding their health care may be a moot point in 1985. Brody (1980) pointed out that once considered "privileged" information was summarilly dismissed with the Patient's Bill of Rights published by the American Hospital Association in 1972. That document not only gave patients the authority to participate in their care, but ensured the preservation of patient values as the basis for treatment decisions. The nurse who takes the Patient's Bill of Rights seriously is faced with many dilemmas in day-to-day practice as she encounters patient inquiries. She may be cast as information giver, but then must decide how much freedom (in the

form of information) to allow the patient. It is generally assumed that the nurse who is willing to become a patient advocate in the hospital environment is one who values autonomy in practice highly, even when autonomy is defined as "self governing; independent; and subject to own laws only" (Mundinger, 1980).

The nursing literature reflects this expectation as depicted in such articles as that by Coogan (1981) and titled, "Nursing in the '90's: Autonomy and High Morale." Another author, Meissner (1981), titled her article, "Your Strength as a Patient Advocate Depends on Your Feelings of Autonomy as a Nurse: How Autonomous are You?" Meissner went on to ask her readers to rate themselves on autonomy.

Questionnaires such as these serve a purpose because they focus the individual nurse's attention on terms that have proliferated in our literature over the past decade. To what degree the rank and file registered nurse claims these dimensions in her practice and in her thinking remains unknown. It was this researcher's goal to study registered nurses to provide information on their views regarding nursing autonomy and advocacy and to relate that to their own self concepts. As Goldstein (1980) reminds us, "favorable self attitudes as a parameter of professional autonomy are drawn from Maslow's hierarchy of needs" (1968). Goldstein (1980) accordingly predicted that the baccalaureate students in their study would score higher on autonomy than those from ADN or diploma programs, and that they would be more "self actualized." She used Mundinger's (1980) observation that "autonomous practice happens whenever a nurse makes an independent judgment about the presence of a health problem and then provides resolution through nursing care."

It is this researcher's contention that if registered nurses view

themselves positively then they may indeed view client concerns in an advocate manner and claim autonomy as necessary for their practice. In light of the researcher's own previous work in the area of self-concept*, and based upon the literature, the following hypotheses were advanced:

1. There will be a positive relationship between nurses' self-concept and their attitude toward nursing autonomy.
2. There will be a positive relationship between nurses' self-concept and their attitude toward client advocacy.
3. There will be a positive relationship between nurses' self-concept and their rejection of traditional role limitations associated with nursing.

Definitions

Self-Concept - the totality of how a person evaluates or feels about himself.

Nursing Autonomy - the nurse's perception of how much latitude nurses have, are allowed, or would be willing to take in functioning as a responsible professional (Pankratz & Pankratz, 1974).

Client Advocacy - how much freedom nurses feel they can allow patients in knowing about and participating in their own care and treatment (adapted from Pankratz & Pankratz, 1974).

Rejection of (Traditional) Role Limitations - the nurse's willingness to openly disagree with the doctor and to become highly involved in the personal matters of patients (Pankratz & Pankratz, 1974).

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*"The self-concept of undergraduate nursing students in relation to clinical performance and selected biographical variables," Journal of Nursing Education, March 1980, Vol. 19, No. 3, 37-44.

Background

When the nurse practitioner role was first described in the early 1960's, it was clear that important dimensions had been added to the role of the nurse. One of these factors was increased professional autonomy (Dachelet & Sullivan, 1979). According to these authors, autonomy implies independence, responsibility, accountability, self-determination and self-regulation. Most of the studies dealing with autonomy of nurses, however, have utilized student nurse samples. Murray and Morris (1982) compared baccalaureate, ADN and diploma senior students on autonomy, advocacy and rejection of traditional role limitations. They found the baccalaureate students higher on all three variables and also re-emphasized that Goldstein (1980) had found baccalaureate students significantly higher than the others on self-actualization as measured by Shostrum's Personal Orientation Inventory. Murray and Morris (1982) recommended that similar testing be done with professional nurses.

An earlier study (Meleis & Farrell, 1974), comparing senior students from baccalaureate, ADN and diploma programs found all three groups strikingly low in self-esteem and also found that there were more similarities than differences between the three groups, i.e., no significant difference on socio-psychological outlook and aspirations for future achievement.

A study by Ellis (1980), using the Tennessee Self Concept Scale to measure self concept levels of baccalaureate nursing students found that self concept levels did vary, being highest at the beginning of the sophomore year and lowest at the beginning of the senior year.

Self-attitudes among registered nurses have not been studied extensively, yet "self-actualization as a parameter of professional autonomy" is frequently referred to by authors writing on autonomy (Maas & Jacox, 1977; Mundinger, 1980).

With regard to autonomy, a large study of registered nurses was undertaken by Pankratz and Pankratz (1974) in testing their own tool on autonomy, patient rights and rejection of traditional role. They report that among their sample of 702 subjects, nursing leaders had significantly higher scores on nursing autonomy and advocacy than did those nurses working in community hospitals. Nursing leaders were frequently associated with universities and had higher educational levels. The more educated the nurse, the more likely they were to also reject traditional role limitations associated with nursing and, as the authors say, these findings "represent one form of validating the scales." They urged others to use their instrument in substantiating results with other groups of nurses. It was the intent of this researcher to study a randomly chosen registered nurse sample and do just that, using the tool developed by Loren and Deanna Pankratz in 1974.

Instrumentation

The Pankratz Nursing Questionnaire (PNQ) consists of 47 statements which can easily be completed in fifteen minutes. It was designed to elicit information about nurses' attitudes toward their professional role and patients' rights. Nursing autonomy and advocacy is operationalized by responses to 26 items; patients' rights is operationalized by responses to 14 items; and rejection of traditional role limitations is operationalized by responses to 13 items. The Pankratz study and the PNQ grew fron the concern that autonomy and independence of practice were not being fostered in basic nursing programs. Dependence vs. independence was considered on three dimensions: 1) dependence vs. independence for the nurse, called "nursing autonomy"; 2) dependence vs. independence for the patient, "patients' rights"; and 3) rejection of

traditional nursing role limitations.

The major validation effort undertaken by the Pankratzes for the questionnaire was in the factor analysis procedure by which the scales were extracted. Two independent and different factor rotations resulted in similar factor loadings of the chosen items. Reliability was based mainly on the consistency of subject responses. This reliability was reinforced by the high consistency of response patterns during three years of use in a nurse practitioner program (Pankratz & Pankratz, 1974).

The tool chosen by this researcher to measure the registered nurses' self-concept was the Tennessee Self Concept Scale developed by William Fitts (1965) at Vanderbilt University. Personal communication with the Scale's author revealed few, if any, studies having utilized this scale with a population of registered professional nurses. The Tennessee Self Concept Scale (TSCS) is a 100-item scale which can be easily completed in 15 minutes. The TSCS consists of 100 self-descriptive statements to which the subject responds on a 5-point response scale rating from "completely true" to "completely false." Ten of these items came from the MMPI L-Scale and constitute the Self-Criticism Score--a measure of overt defensiveness. The other 90 items were drawn from a large pool of self-descriptive statements. The original criterion for selection was agreement by seven psychologists as to the classification of the items on the basis of their content (Fitts, 1965).

In addition to the Self-Criticism score (SC), the TSCS yields six major types of scores: a self-esteem or Positive Score (P), Variability of Response (V), Distribution of Responses (D), Net Conflict Score (C), Empirical Scales differentiating norm-referenced from deviant groups (a total of six scales compose this analysis) and, finally, a profile score on the Number of Deviant

Signs (NDS). The NDS, like the Empirical Scales, is an empirically-derived measure, being simply a count of the number of deviant features of other scores--as such, it is the TSCS' best index of psychological disturbance. Many investigators report only a few of the possible scores listed above; most often these are the total P score (self-esteem) and the SC score (self-criticism score).

The Tennessee Self Concept Scale has been well documented in its usage. The test-retest reliability coefficient for the total positive score was reported as .88 (Fitts, 1965). Fitts also discussed the content validity, discrimination between groups, and concurrent validity at length. All TSCS subscales discriminate between patients and non-patients, mostly at the .001 level of significance.

Sampling Plan

A random sample of 300 female nurses was obtained from the Missouri Directory of Registered Nurses. Usable responses numbered 106, making the response rate 35.3%.

All subjects received mailed packets containing a cover letter, the Tennessee Self Concept Scale (TSCS), the Pankratz Nursing Questionnaire (PNQ), and demographic questions devised by the researcher which included basic nursing education, highest degree held, year RN received, years active in nursing, current employment status, position, and field or practice area in nursing.

Data Analysis

The TSCS was scored by computer by the test publishers, and the PNQ was hand scored. Frequency counts were done on the demographic variables. TSCS and PNQ data were analyzed using Pearson correlations from an SPSS program.

FINDINGS

Description of the Sample

The 106 registered nurses who responded to the study were all female and ranged in age from roughly 25 years to 69 years. Respondents (N=106) classified according to basic nursing education were as follows: diploma-62.3%; associate degree-17.9%; baccalaureate-19.8%. According to the highest degree now held, the total group could be categorized:

Diploma	52.8%
Associate Degree in Nursing	16.0%
Associate Degree, Other Field	.9%
B.S.N.	17.9%
Bachelor's Degree, Other Field	2.8%
M.S.N.	4.7%
Master's Degree, Other Field	4.7%

One can see from these figures that nearly 10% of those who were original diploma graduates went on to receive a degree of some kind. When all respondents were asked whether they planned to pursue an advanced degree, however, 49.1% said no; whereas, 30.2% said yes, in nursing. The rest (12.2%) were undecided or planned to pursue a degree in another field (8.5%).

Most of the nurses in this sample were married (78.3%), while 15.1% had never married and 6.6% were either separated, divorced or widowed. Sixty-six percent were employed full-time during the past year, and of those, 73.6% were employed in the same position one year ago. Perhaps the days of excessive turnover in nursing are abating due to economic conditions. These figures at least seem to reflect some stability in employment. Almost 60% (59.4%) of the

nurse respondents work in hospitals. The next largest employer is home health agencies with 7.5% of the sample employed there. The rest were rather evenly divided between nursing homes, schools of nursing, schools, industrial settings, and doctors' office settings. Fifty-two percent were staff nurses which made this a "rank and file" nurse sample above the researcher's expectations. Only 10% were head nurses; another 8% were instructors and 6% were supervisory personnel. Only 6% were administrative nurses and the remainder held miscellaneous designations, i.e., central supply, inservice staff, float pool, etc.

Hypotheses Considered

The first hypothesis, that there would be a positive relationship between nurses' self concept and their attitude toward nursing autonomy was not supported by data collection. Although the correlation was in a positive direction, it was not significant.

The second and third hypotheses predicted a positive relationship between self concept and client advocacy, and between self concept and rejection of traditional role limitations. These hypotheses were supported by data collection (see Table 1). Statistical analysis using Pearson correlations yielded significance at the .001 and .05 level respectively.

Table 1

Registered Nurses' Self Esteem Related to Patient Advocacy Attitudes and Rejection of Traditional Role Limitations (N=106)

	Self Esteem*	
	r	p
Advocacy+	.293	Less than .001
Role Rejection+	.191	Less than .05

*Self esteem as measured by the Total Positive Score from the Tennesses Self Concept Scale (TSCS)

+Patient advocacy and role rejection measured by the Pankratz Nursing Questionnaire (PNQ) developed by Pankratz & Pankratz (1974)

Additional Findings

The registered nurses in the current sample compared favorably with this researcher's earlier work using sophomore nursing students and testing self concept levels (Burgess, 1980).

Table 2 Here

With regard to results on the TSCS, the 106 subjects evidenced a wide range of P scores (self-esteem) from a minimum of 303 to a maximum of 423, with 364.8 being the mean. This mean compares very favorably to that obtained (346.6) from sophomore nursing students (see Table 2 for comparisons). Persons with high P scores tend to like themselves, feel that they are persons of value and worth, have confidence in themselves, and act accordingly. People with low scores are doubtful about their own worth; see themselves as undesirable; often feel anxious, depressed, and unhappy; and have little faith or confidence in themselves (TSCS Manual, p. 2). The mean self-criticism score reported by the 106 registered nurses was 35.6, compared to 35.4 for the nursing students and 35.5 presented as the normative mean based on 626 subjects as reported in the TSCS manual. If the self-criticism (SC) score is low, high P scores become suspect and are probably the result of defensive distortion.

Column C scores on the TSCS represent the personal self of the subject. This scores reflects the individual's sense of personal worth, his feeling of adequacy as a person and his evaluation of his personality apart from his body or his relationship to others. The norm mean reported in the TSCS manual is 64.5, which compares fairly closely to that evidenced by the nursing students (67.6) and for the registered nurses (69.3).

The Personality Integration (PI) scale is considered as reflective of persons judged as average or better in terms of level of adjustment or degree

Table 2

Tennessee Self-Concept Scale:
Normative Group, Nursing Students, and RNs

Tennessee Self-Concept Scores	Normative Sample (N=626)		Nursing Students (N=101)		Registered Nurses (N=106)	
	Mean	Standard Deviation	Mean	Standard Deviation	Mean	Standard Deviation
Total Positive (Self-Esteem)	345.57	30.70	346.63*	31.64	364.83*	26.67
Self-Criticism	35.54	6.70	35.46	5.74	35.67	5.26
Personal Self	64.55	7.41	67.10	7.81	69.33	6.89
Personality Integration	10.42	3.88	11.45	3.59	12.39	3.86
Number of Deviant Signs	7.3	----	6.7	----	5.99	----
Number of Integrative Signs					19.1	
Self-Actualization					35.1	

*Means significantly different, $p < .001$

of personality integration. The nurses students reported a mean score on this scale of 11.7 and the registered nurses reported a mean of 12.3, which compared favorably to a mean of 10.4 reported for the norm group.

The last score to be included in the analysis was the NDS or Number of Deviant Signs, which is a purely empirical measure and is simply a count of the number of deviant features on all other scores. As such, the NDS score is the Scale's best index of psychological disturbance. This score alone identifies deviant individuals with about 80% accuracy. The mean (6.7) reported for the nursing students is close to the actual mean of 7.3 reported for the norm group. The registered nurses reported a mean of 5.9 on this subscale score.

One can easily see from Table 2 that on the basis of group norms, the registered nurses scored higher than the nursing students (Burgess, 1980) on all subscales of the TSCS, except the Number of Deviant Signs, and these were less in the registered nurses. The self esteem mean for the registered nurses was compared to that for the nursing students using a student's t-test, and the means were found to be significantly different at the .001 level. The last dimension of the TSCS listed for the registered nurses but not for the nursing students is a relatively new subscale called the Number of Integrative Signs (NIS) and indicates an overall degree of personality integration as derived from all subscales. This NIS score can, in turn, be used to derive a self acutalization (SA) score, thus: SA = 2(NIS) - NDS (Number of Deviant Signs). The registered nurses in the current sample compared very favorably to those adults studied and reported by Fitts (1972). His study yielded an NIS mean of 17.4 for 1205 adult subjects; registered nurses in this sample reported an NIS mean of 19.1; his adult sample yielded an SA (self actualization) mean of 26.02, while the registered nurses in this sample reported an SA of 35.1, which is considerably higher.

Other Findings

Some other findings encountered by data collection were these (see Table 3): a positive correlation between autonomy and highest degree held, which supports findings by Pankratz and Pankratz (1974) referred to earlier; a significant negative correlation between autonomy and years active in nursing, which ranged from 1 to 32 years for this nurse sample. The negative correlation means that there is a negative relationship between age and autonomy for these nurses, i.e., the older the nurse, the less autonomy evidenced. This was not an expected finding. Not as surprising, however, are the two other findings shown in Table 3, namely a significant positive correlation between autonomy and personal self score, and between autonomy and personality integration scores. This means roughly that the more favorably nurses view themselves as evidenced by these subscales of the TSCS the more they favor autonomy. The bottom line is that it takes fairly healthy, well-integrated persons to want autonomy for themselves. These correlations may be taken as support for the first hypothesis, which predicted a positive relationship between autonomy and self concept, even though the major self esteem (total positive) score did not significantly correlate with autonomy as mentioned earlier.

Table 3 Here

One additional finding of interest was the PNQ means for autonomy, advocacy (patient rights) and role rejection reported by this registered nurse sample (N=106). These means are depicted in Table 4 compared to community hospital nurse employees (Pankratz & Pankratz, 1974) and senior nursing students (Murray & Morris, 1982).

Table 4 Here

Table 3

Nurses' Attitudes Toward Autonomy Related to Highest Educational Degree Held, Years Active in Nursing, and Selected Self Concept Variables[+] (N=106)

	Autonomy Score	p
Highest Degree Held	.389	Less than .001
Years Active in Nursing	-.364	Less than .001
Personal Self Score*	.200	Less than .05
Personality Integration Score**	.174	Less than .05

[+]As measured by the Tennessee Self Concept Scale

*Personal Self Score reflects sense of personal worth, apart from body image.

**Personality Integration Score reflects level of adjustment in general.

Table 4

Autonomy, Advocacy, and Role Rejection Means:
Comparison of Three Sample Groups

	N	Autonomy	Advocacy	Role Rejection
Senior Nursing Students				
Community College	80	82.7	58.4	51.1
Diploma Program	85	86.9	57.9	52.1
University	59	92.8	61.6	53.7
(Murray & Morris)				
RNs	200	74.8	54.1	46.0
(Community Hospital - Pankratz & Pankratz)				
RNs, Current Sample	106	83.6	58.4	46.3
(Random; Missouri Directory)				

The RNs in the current sample most closely paralleled the means for the ADN senior students, except for role rejection, where the RNs scored lower than the senior students. This factor measures the nurses' willingness to openly disagree with the doctor and to become highly involved with the personal matters of patients. On this dimension, the current registered nurse sample (Mean - 46.3) was close to the nurses studied by the Pankratzs (1974), who worked in community hospitals (Mean - 46.0). Perhaps the composition of the current sample, who are also largely employed in hospital settings, accounts for the comparable findings.

Summary and Conclusions

This study examined a random sample of female registered nurses (N=106) from a midwestern state utilizing the Tennessee Self Concept Scale (TSCS) and the Pankratz Nursing Questionnaire (PNQ) together with demographic data to determine the relationship between nurses' self concept and their attitudes toward autonomy, client advocacy, and rejection of traditional role limitations associated with nursing. The registered nurse respondents scored high on all selected dimensions of the TSCS. There was a significant relationship revealed between self concept and advocacy, and between self concept and rejection of traditional role limitations. In addition, there was a significant positive correlation between autonomy and highest degree held. Unexpectedly, there was a significant negative correlation between autonomy and years active in nursing, which ranged from 1 to 32 years for this nurse sample. Hence, the older the nurse, the less likely she is to value autonomy. This factor (autonomy), as identified by Pankratz and Pankratz (1974), measures the extent to which nurses feel comfortable in taking initiative and responsibility in the hospital themselves, without permission from an administrative nurse, that is, trying

new approaches to patient care. Perhaps it remains for the newly graduated to carry the concept of autonomy into the work setting, particularly the home health setting which is sure to be a heavy employer of nurses in the next decade. Thus, as the Pankratzes noted, the interest is not only in how much freedom nurses see for themselves, but how much freedom they can allow the patient. It is assumed that nurses can be of more value to the patient as they use their autonomous role to become the patient's advocate.

Recommendations for further study would include home health care nurses and how they view autonomy and advocacy and perhaps how they see themselves operationalizing these concepts in daily practice. It may be that the home care environment creates a more favorable climate for reciprocity between nurse and client, and for promoting both autonomy and advocacy to a greater extent than heretofore measured.

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